Mental Health Care (U.K) Limited

Acrefield House

Inspection report

Acrefield House
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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Inadequate**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 13, 16 February and 6 March. All three visits were unannounced.

Acrefield House is a large Victorian style detached building in a residential area of Prenton, Wirral. The building is over three floors, with well-kept front and rear gardens. The home is registered to provide care and accommodation for up to 12 people. At the time of our visit 10 people were staying at the home.

Accommodation is in 12 bedrooms over three floors, the upper floors are accessible by a staircase. There is a ground floor extension at the rear of the building providing accessible bedrooms. All of the bedrooms are single occupancy. There are suitable toilets, and bathing facilities on each floor.

The home required and had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

During our inspection we found breaches of regulation 11, 12, 13, 16, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also found breaches of Regulation 18 of Care Quality Commission (Registration) regulations 2009. Failure to notify the Commission of notifiable incidents.
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

During our inspection we found that there had been failings by the registered manager to alert the CQC of notifiable events and to alert the local authority of incidents and allegations that are reasonably considered to be safeguarding alerts. There was also a failure of the registered manager to investigate specific safeguarding allegations. As a result of the inspection safeguarding alerts were made to the local authority by the CQC for five people living at the home.

People at the home had not been kept safe. Risk assessments had not been effective in reducing risks. At times physical restraint had not been used in a safe way. Altercations between people living at the home caused people to be upset and not feel safe.

Incidents had been recorded, but this information had not been used to reduce the likelihood of any reoccurrence. There was little evidence to suggest staff and people living at the home were de-briefed and supported after any incident.

Staff told us that often staffing levels were lower than those that had been planned.

Staff told us that they liked working at Acrefield House. But they told us they were not confident in supporting people during challenging situations and that appropriate guidance was not in place for them to be effective supporting people. Different staff members responded in different ways, which led to inconsistent support and at times unsafe and inappropriate use of restraint.

There was a poor culture amongst the staff team, there was in fighting amongst the staff. One staff member commented on how this has had a negative effect on the atmosphere at the home where people lived.

The support provided was not in line with the Mental Capacity Act 2005. In people's care files information relating to people's mental capacity and deprivation of liberty safeguards was incomplete and at times contradictory. The registered manager had failed to give relevant information to a person's legal representative. This meant that the person's legal representative did not have relevant information to make decisions that were in the person's best interests.

During our inspection staff had a caring approach to people and we saw they were at times considerate of people. Staff spoke positively about the people they supported and were keen to tell us of the progress some people had made and positive experiences such as going on holiday. However there were mixed opinions from people supported about the support staff.

However because of the prevailing culture at the home, people's support was not always caring. We found the atmosphere to be tense at times. When we spoke with staff many of them also told us of divisions and in-fighting amongst the staff team. One staff member told us that this impacts on the atmosphere in people's home. Although staff listened to people on a regular basis with regard to their care, the organisation had not investigated people's concerns or taken effective actions to resolve them. People's verbal and non-verbal communication was not always listened to.

People had personalised care plans which recorded their needs and preferences. We saw that this information was reviewed regularly. However the reviews had not always led to changes in people's care plans, new information being added or actions being taken.

Acrefield House lacked clear leadership and good governance. There was a poor culture amongst the staff team which was well known. The registered manager had not assessed and monitored people's care to a

sufficient degree so that he was able to be assured that it was of good quality. There was poor communication with other professionals involved in people's lives.

Medication was usually administered safely, there had been some recent medication errors that the provider had investigated and was addressing.

We saw and people told us that they were supported to engage in activities within the home and in their community. People were supported to engage in everyday activities such as going to the cinema, the local church, shopping, to local coffee shops and further for trips out. Some people had been supported to take a holiday.

The environment within the home was clean and well maintained. It was decorated in a homely and non-clinical style. Some bedrooms had been recently renovated to a high standard. There were safety features of the building that ensured people were kept safe. People who wished to show us their rooms told us they were happy with them and they had been supported to personalise then.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Appropriate safeguarding referrals had not been made by the registered manager.

Risk assessments were inadequate and did not offer guidance for staff to anticipate and mitigate risks.

The use of restraint was not safe.

Planned staffing levels were sufficient to meet people's needs. However staff told us staffing levels were frequently lower than planned.

Medication was not always administered safely.

The physical environment was safe.

Is the service effective?

Inadequate

The service was not effective.

The Mental Capacity Act 2005 was not implemented to protect people's rights.

People were not listened to, their actions were showing that they did not give consent to their care and treatment at the home.

Staff had received training. However they didn't have the necessary guidance to be effective in all aspects of their role.

The staff team did not have the skills, competencies and experience to support people in challenging situations.

The physical environment was homely. People told us they liked their rooms.

Is the service caring?

Inadequate

The service was not caring.

Individual staff members were caring. We saw positive and caring interactions between people and staff.

Because of dis-unity amongst staff, the atmosphere in people's home was at times tense.

People were not listened to in their words or actions. The organisation had not adequately investigated people's concerns or taken effective actions to resolve them.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans contained personalised information. However There was evidence that this information was not always used to guide people's support.

It was not always recorded what actions had been taken as a result of complaints received.

People were supported to participate in a range of day to day activities.

Is the service well-led?

Inadequate

The service was not well led.

The registered manager had failed to notify the CQC of events which they had a statutory obligation to do so.

There was a poor culture amongst the staff team.

The registered manager had poor communication with other professionals involved in people's care.

The registered manager had not assessed and monitored people's care to a sufficient degree to be assured that it was of good quality.

Internal quality assurance visits had not been effective.

Acrefield House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 13, 16 February and 6 March 2017 and was an unannounced inspection. The first two days of the inspection was completed by two adult social care inspectors, the third day was undertaken by one inspector.

Before the inspection, we looked at information the Care Quality Commission (CQC) had received about the service including notifications received from the registered manager. A notification is information about important events which the provider is required to send us by law. We checked that we had received these in a timely manner.

We also contacted the local authority quality assurance team for their feedback.

We spoke with five people who lived at the home. We also spoke with two relatives of people who lived at the home. We spoke with 14 members of staff including the registered manager and deputy manager, eleven support workers and one domestic staff member. We also spoke with the quality lead from the providers head office.

We spoke with one visiting health professional and one person who frequently visited the home to engage in activities. We also spoke to an independent advocate who visited the home.

We observed people's care and staff interactions with people who lived at the home. We looked at the care plans for four people. We also looked at the staff files of six members of staff. We looked at documents relating to medication administration, health and safety, staff rotas, quality assurance, incidents and accidents, and the management of the home.

Inadequate

Is the service safe?

Our findings

We asked people if they felt safe and liked living at Acrefield House. People gave us a mix of responses. One person told us they felt safe and that staff treated them well. Other people told us that they didn't feel safe. One person told us of an incident that had happened that morning that had caused them upset.

One staff member told us, "It's safe. I feel some days it could be safer, with last minute sickness we can be stretched. Altercations between service users can cause a domino effect."

Staff had received training in safeguarding vulnerable adults. Some staff had raised safeguarding concerns with the registered manager. Their concerns had not always been acted upon.

The registered manager had failed to notify the local authority of incidents that are reasonably considered safeguarding alerts. There was a failure by the registered manager to investigate specific safeguarding allegations that had been brought to their attention by staff members.

There were repeated and targeted physical altercations between people living at the home. Many of these had been documented and there was a clear and recognised pattern that had not been investigated or resulted in any safeguarding referrals being made. This meant that people were not safe living at the home.

As a result of our findings CQC raised safeguarding alerts for five people living at Acrefield House.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were not protected from abuse and improper treatment.

The registered manager told us that when necessary the staff used a recognised method for de-escalating crisis situations and as a last resort physical restraint to keep a person safe. The organisation had provided training and training refreshers for staff in this method.

However we saw in documentation and staff told us that restraint was used inconsistently by staff. One staff member told us it was, "Not clear what we should do."

There are incident records that show that the use of restraint was not always safe or a proportionate response to the immediate risks present. It was not always the least restrictive option and it was not always used for the minimum amount of time. Care plans did not clearly outline when restraint may be necessary or what techniques to use to de-escalate a situation which should be used first. We saw in one person's care file information that may help to deescalate a situation for one person that were not being used by staff.

From the descriptions in incident documentation it was clear that the authorised techniques that staff had been trained to use, were not always the methods of restraint that staff were using.

There was little evidence that there were any debriefing opportunities for the staff and the person being restrained. Incidents were not used to learn how to change and improve the practice of staff at the home in supporting people.

Risk assessments were inadequate and had not been updated with relevant information from repeated incidents. They did not offer sufficient guidance and support for staff in how to anticipate and mitigate risks. This led to staff developing their own approaches, methods and style which varied greatly amongst the staff team.

The inconsistent methods of restraint used by staff; staff not always using them in a safe way as authorised by the supplied training; staff not using restraint for the minimum amount of time or as a proportionate response to the immediate risk; not following information in people's assessments and no debriefing and learning from incidents taking place meant that the use of restraint at Acrefield House was not safe and placed people at serious risk of harm.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During challenging situations people did not receive care and support that was safe.

The home had a registered manager, a deputy manager, four team leaders and a team of support workers. They were also supported by a cleaner and a maintenance person. There was a total staff team of 49. Each 'shift' had a designated 'shift leader' which was either a team leader or a designated support worker. The registered manager told us the aim was to have seven or eight staff per shift, plus a shift leader or team leader.

One person showed us a call bell they had in their room. They told us that they used it when they needed help from staff. They pressed the call bell and staff quickly attended. Feedback from staff was that due to sickness and staff not showing up they were often short staffed. Some staff told us that this at times stopped people being able to go out as they could not offer sufficient support.
It was unclear as to whether staffing levels were always within safe limits to meet people's care needs.

The medication was stored in a small room which was cramped and hot. It was not a warm day; the staff member told us that the window did not open as it was broken. The temperature of the room was close to the maximum recommended for the storage of medication. It was 24 degrees Celsius and most medication requires storing below 25 degrees Celsius. The staff member told us that when the room got hot they used a fan. However this may not be sufficient in warmer months.

The room contained an appropriate method for disposing of waste and a wash basin for good hygiene. Medication was stored securely, either in the medication room or in a secure cabinet in people's bedrooms. Nobody was currently using controlled drugs at the home. The medication room was orderly and the system for administration was clear. Each person had a medication file which contained a picture and description of each medication. The staff member told us that there were always two staff members responsible for medication, an administrator and a 'buddy' to check the process was being followed.

As and when required (PRN) medication was recorded and stocks were checked every day. We checked the stocks of PRN medication for three people and these were correct. There were recent increasing patterns in people's use of PRN medication, we were told there was no formal way of monitoring this, to ensure it was being used appropriately.

Medication was blister packed on a 28 day cycle, the day of our visit was day one on a cycle so we were only able to check one day's medication administration as the previous blister packs had been disposed of. The medication we could check and the medication records were up to date and signed.

The staff member told us that completed MAR charts were not checked for completeness; rather it was the responsibility of each staff member to check the administration before. We noticed there was one omission to sign on the previous MAR chart, this had not been addressed. There was also a refusal of medication marked as 'R' when the code for this on the MAR was 'Z'. This had been incorrectly recorded. There had been one medication error a month for the past three months. The provider was looking into the causes of these and had revised plans on assessing the competency of staff to administer medication at regular intervals.

We looked at the environment of the home and saw that it was clean and well maintained. During our visit one of the bedrooms was being fully refurbished. We saw that the toilet and bathroom facilities were clean. There was a daily cleaning log that had been filled out on most days, showing that the facilities had been cleaned. There were no unpleasant odours at the home.

Measures had been put in place to ensure the environment was safe. Opening windows had restrictors in place. Fire exits were clearly marked and were clear of obstructions. There was appropriate use of fire doors and fire fighting equipment was in place that had been recently serviced. On the first floor there was a locked cupboard that was being used for the safe storage of potentially hazardous cleaning chemicals.

The second entry door to the building was secured by a keypad. This was to ensure that people who required support to access the community safely had the appropriate support before they left the building.

Inadequate

Is the service effective?

Our findings

We found that the requirements of the Mental Capacity Act 2005 (MCA) were not followed. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and be as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

One person's DoLS had been granted with conditions. The provider as the managing authority had responsibility for ensuring these conditions were met. The provider had not met or made sufficient progress to meet conditions on the DoLS. This means that the DoLS may no longer be in the person's best interests and the deprivation of liberty was unlawful.

The registered manager had given an inaccurate account of and failed to provide relevant information regarding one person's support to their relevant person's representative. The relevant person's representative's (RPR) role is to represent a person who lacks capacity and has been deprived of their liberty under DoLS. Because the registered manager had not provided accurate information to the RPR, the RPR would not be able to act in the best interests of the person they represented. This means that with inaccurate or partial information poor decisions may be made with regard to the person's care and treatment that are not in the person's best interests.

The home had a secured door which stopped people from freely leaving the home. It was clear from records and what staff told us that one person had stated verbally, and by their actions was showing that on many occasions they wanted to leave the building. The person had been physically restrained when attempting to leave the building. The provider had not given regard to the communication from the person that they objected to a DoLS that was in place. Other people at the home had by their actions shown that they may not be giving their consent to aspects of their care and treatment. There was a failure by the provider to review, 'listen' to people and act on people's verbal and non-verbal feedback.

In people's care files information relating to people's mental capacity and deprivation of liberty was incomplete and at times contradictory. We shared our findings with the appropriate authorities.

These are breaches of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In their care and support of people, the registered person had not acted in accordance with the Mental Capacity Act 2005.

Staff at the home told us they had received training relevant to their role. Staff initially received two weeks of

induction training, with periodic refresher training. There had been a return to face to face training which the staff told us they preferred. One staff member told us, "The trainers were very down to earth and were good." Another staff member told us, "Training is better now than it used to be. There is better training now for newer staff." Some staff told us they had been supported to obtain further qualifications.

Training included a recognised method for de-escalating crisis situations and as a last resort physical restraint to keep a person safe. The training method was called 'The Management of Actual or Potential Aggression' (MAPA). Staff told us they were unsure of how and when this training applied to the people they were supporting and there were differences in how staff used the training. The training had not equipped staff with the necessary skills to support people safely who may offer challenges.

Staff comments about the application of MAPA training included; "Some staff are afraid to use MAPA"; "All (staff) are unsure when to use, it can lead to using in different ways"; "Different staff react in different ways, It's a big problem. Staff don't respect boundaries, they chop and change"; "Some staff give in to everything, some staff are wary". The staff member gave an example of a situation and told us, "Some staff are not able to challenge this. It's not a lack of training, people (staff) are frightened" and another staff member said; "I'd be quite happy if MAPA was ditched".

One person who visited the home told us that they witnessed different staff supporting the same person differently, causing problems. They told us that some staff tried to de-escalate situations and others took challenges personally saying, "How dare you speak to me like that", escalating the situation. One staff member commented about their colleagues, "Certain people (staff) give them (people supported) a reaction".

There wasn't a unified or consistent team wide approach with regard to supporting people. Staff members told us their individual approach and what had worked for them. Some staff told us that there had been a meeting to explore approaches to support but this had not worked. Recently the manager had developed core teams to support certain people to help improve consistency.

The staff team's inconsistent and disunited approach to supporting people who challenge and altercations between service users was having a negative impact on the quality of life of the people living at Acrefield House. Not providing the staff with appropriate on-going support and guidelines had meant the training they had received became ineffective.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staff did not have the skills, competencies and experience to support people in challenging situations.

The home was tastefully decorated in a homely, non-clinical style. There was a TV lounge; we saw that three people were using this lounge to watch a movie. There was a games room with a games console, stereo equipment along with games and activities equipment that people could choose to use. One person had an electric drum kit that was set out in the room.

People who wished to showed us their rooms. We found people's rooms to be of a reasonable size and well decorated. People had been supported to personalise their rooms with furniture, pictures and other memorabilia. Some people had the own TV's and stereo equipment in their rooms. Some people had chosen to place a sign on their room door, with pictures of things that were meaningful to them.

Some people had hoist equipment installed in their rooms. This equipment was also available in some of

the bathrooms so they could be used by people with limited mobility.

Inadequate

Is the service caring?

Our findings

The approach of staff towards people that we observed was caring and considerate. Staff members appeared to care about people and we observed positive and warm interactions between people.

We asked people living at the home if the staff were kind to them. Some people told us, "Yes." Other people didn't agree. One person told us, "Some of them are, not all of them are." Another person said, "Most of them are alright." They then told us the names of two staff members they liked.

One family member told us, "I think the staff are very caring." They added, "It's a lovely, homely atmosphere."

Staff members spoke about people they supported positively. They were keen to tell us of the progress some people had made in their life skills and experiences they had shared with people, such as going on holiday together.

However because of the prevailing culture at the home, people's support was not always caring. We found the atmosphere to be tense at times. When we spoke with staff many of them also told us of divisions and in-fighting amongst the staff team. One staff member commenting that this impacts on the atmosphere in people's home. Although staff listened to people on a regular basis with regard to their care, the organisation had not investigated people's concerns or taken effective actions to resolve them.

People's verbal and non-verbal communication was not always listened to.

Some people at the home had expressed repeated frustration with certain situations. Whilst staff stood and listened the organisation was not taking appropriate action. During our visit one person showed frustration and was upset about an incident that had happened earlier. Whilst the staff stood and listened respectfully, we had to ask for this to be documented. Not documenting a person's expressed point of view can impact on planning the future care and support the person requires and is expressing a wish for. This shows that interactions with people were not always meaningful for the person.

People had easy read complains log and easy read information about DoLS. However these did not lead to open and transparent responses to concerns or complaints people had raised. Although staff listened to people on a regular basis with regard to their care, the organisation had not investigated people's concerns or taken effective actions to resolve them.

There was a lack of continuity in supporting people who lived in the home. This meant that staff were failing to care for people in a caring way. Staff did not consider how their actions in difficult situations were impacting on the people's well-being and quality of life.

Requires Improvement

Is the service responsive?

Our findings

People's care plans contained relevant personal information. There was information regarding significant people in the person's life, such as people's next of kin, relatives and friends. Plans contained information on people's preferences such as food preferences and what activities they liked to do.

There were guidelines for staff on how to support people with their health needs, hygiene, finances, diet, sleep, mobility and other needs specific for the person.

People's care plans contained daily notes of what the person had been doing. These gave an overview of how they spent their day. There was evidence that this information was reviewed as part of a monthly evaluation. This evaluated people's support with their health, diet, mobility and any other significant issues. Some of these evaluations had mentioned the same significant issues for many months without any record of what was being done to address or support a person with these issues. At times the concerns highlighted had not led to new information being added or a review of the person's care plan. This meant that people's care plans did not always contain up to date guidance for staff. The organisations quality lead told us that people's care plans were, "Not up to the standards expected".

Complaints were recorded on the organisations computer system. We looked at the record of complaints. Some complaints received had been investigated and a written reply had been given to the person about the complaint. We also found that some records contained limited information of the complaint and others contained no information on actions that the registered manager was taking. This meant that people could not be confident their concerns or complaints were taken seriously and acted upon. People at times expressed unhappiness with situations through verbal and nonverbal communication. This was not always acted upon.

These are breaches of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. All complaints were not investigated and necessary and appropriate action taken.

The home supported people with a range of activities. We saw that there were plans in place for a Valentines party. We were told that each Friday was a 'Sweet Friday', during which people were encouraged to get involved with baking homemade cakes.

People care plans contained a record of activities people took part in. These included trips out of the home for sightseeing or coffee, shopping, visit and volunteering at a local church and visiting the local cinema. One person told us that they were supported to go to the home games of their local football team.

We saw that there was a 'resident's birthday list', which made sure that each person's birthday was acknowledged and celebrated. The deputy manager told us that some people wanted a party at home, other people went out with their family, or went with other people for a meal out. It was, "Geared around each resident".

There was a white board in the staff room which contained important up to date information to be put into action by the next shift. This could be upcoming appointments or visitors to the home. Whilst this is useful to staff it was on display in a room that was accessed by professional visitors to the home and was opposite a door. We asked the deputy manager to give regard to any personal information about people that could be put on display.

On a notice board near the manager's office there was easy read information telling people how they could make a complaint and obtain the support of an independent advocate. However our findings at this inspection showed that this information had been of limited value to people in supporting them to obtain improvements to their care and support.

Inadequate

Is the service well-led?

Our findings

The home had a registered manager in post as required by their registration with the Care Quality Commission (CQC). Some staff members told us they thought the manager was approachable and supportive. Other staff members told us he was unapproachable.

The registered manager at Acrefield House had failed to notify the Care Quality Commission of events that he had a statutory obligation to report. These included a number of DoLS authorisations and seven occasions when he was aware that allegations of abuse had been made.

This is a breach of Regulation 18 of Care Quality Commission (Registration) regulations 2009. Failure to notify the Commission of notifiable incidents.

The registered manager told us that he had been supported in his training and development to become a registered manager. He told us he enjoyed working with people. The registered manager said that he had support on the phone, regular managers meetings in head office and spoke to his line manager in person or on the phone weekly.

The registered manager told us that he put, "The residents first by ensuring staff are good." We asked the registered manager if there were any issues in the staff team. He initially told us that some staff were unhappy about there no longer being a full time cook and people living at the home being encouraged to get involved with staff making meals. Some staff had been so upset by this that they left. He told us he was using supervision to sort out these difficulties.

However it became clear during our inspection that there was friction and difficulties between staff members and there was a poor culture at the home and this was having an impact on the support people received.

Staff told us and we saw documents with regard to; complaints between staff members; safeguarding allegations between staff members; bullying allegations and grievances between staff members. We learnt of two staff members who had been suspended. We found that the registered manager was being evasive with the CQC with regard to his responses and information he provided about the staff team.

One staff member told us, "We are not a united staff team. The atmosphere grinds you down, it's uncomfortable. You notice that people don't get on. Sometimes you feel awkward going from one room to another. There are cliques. If it impacts on us, it's going to affect them [people supported]". Another staff member told us, "We don't all sing from the same hymn sheet". We asked one professional visitor if they would be happy if one of their relatives stayed at the home. They told us, "I love Acrefield, but the answer is no, I would not. Perhaps because there is such a mix of personalities between the staff".

We found that Acrefield House lacked clear leadership and good governance.

The registered manager had not assessed and monitored people's care to a sufficient degree so that he was able to be assured that it was of good quality. There were aspects of the running of the home that should have demanded his immediate attention. For example the registered manager told us about the support of one person where they felt they were able to meet their needs but it has an impact on other residents, this impact had not been assessed or mitigated; there had been a recent sharp increase in some people's use of medication for anxiety, this had not been assessed or mitigated; and there were allegations of abuse on record that had not been investigated. The registered manager and other staff told us of two staff members "Going AWOL" and not returning to the home. The registered manager did not know if they were still employees and had not fully investigated the reasons for this.

The registered manager told us that they had been, "Blinded by staff issues" in regards to investigating allegations that had been made at Acrefield. However there was little evidence that the registered manager had taken steps to resolve issues amongst the staff team or had taken advice on these issues.

The registered manager had also not communicated important information about one person's support to their assigned health professionals or the commissioning authorities. This meant that all relevant information about the person had not been given to them in order for them to assess, plan and direct the person's care. He also failed to give accurate and timely information to one person's representative in regard to their Deprivation of Liberty Safeguards (DoLS).

The nominated individual completed quality assurance visits and produced a Nominated Individual Visit Report. The report from February 2017 noted, yet had not explored the impact of altercations between people living at the home. It also did not explore the 17 recorded incidents in January, the month previous. During our inspection we found some of these incidents highlighted areas of concern, one incident had been raised as a safeguarding after a staff complaint and a second incident was raised afterwards by the Commission as a safeguarding matter. The nominated individual's visit had not led to any actions by the provider in these areas. This meant that the provider was also failing to recognise the significant problems that were in the home.

Incidents and complaints were recorded on the organising computerised recording system. The registered manager told us that these were, "Reviewed by head office." There is no evidence that the information recorded on this system had led to any questioning of the quality of the support provided at Acrefield House by more senior members of staff. The failure of these systems led to people receiving a poor service that did not listen to them and at times meant they were not receiving safe care.

These are breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered manager and provider had not assessed and monitored the services provided to people, in order to improve their quality; and they had not adequately assessed, monitored and mitigated risks relating to the health, safety and welfare of service users.